

AMENDED IN SENATE JUNE 10, 2010

AMENDED IN ASSEMBLY APRIL 20, 2010

AMENDED IN ASSEMBLY APRIL 6, 2010

AMENDED IN ASSEMBLY MARCH 22, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL

No. 2042

Introduced by Assembly Member Feuer

February 17, 2010

An act to add Section 1374.255 to the Health and Safety Code, and to add Section 10199.49 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 2042, as amended, Feuer. Health care coverage: rate changes.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, no change in premium rates or coverage in a health care service plan contract or a health insurance policy may become effective without prior written notification of the change to the contractholder or policyholder. Existing law prohibits a plan or insurer during the term of a group plan contract or policy from changing the rate of the premium, copayment, coinsurance, or deductible during specified time periods.

This bill would prohibit a health care service plan or health insurer from altering the rates that apply to individual health care service plan

contracts or individual health insurance policies, or altering any benefits included in individual contracts or policies, more than once each calendar year, except as specified. *Among those exceptions, the bill would require the cost sharing for a prescription drug for an enrollee or an insured to be reduced if a brand name drug becomes available as a generic drug and other conditions are satisfied. The bill's provisions would apply to a new individual plan contract or policy issued to an enrollee or insured who transfers from another plan or policy, as specified, and would prohibit the issuance of new plan contracts or policies more often than annually.*

Because a willful violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 1374.255 is added to the Health and
- 2 Safety Code, to read:
- 3 1374.255. (a) For purposes of this section, "rate" includes, but
- 4 is not limited to, premiums, copayments, coinsurance obligations,
- 5 deductibles, out-of-pocket costs, and any other charges for covered
- 6 benefits.
- 7 (b) Notwithstanding any other provision of law, except as
- 8 required by changes in state or federal law or as provided in
- 9 subdivision (c), a health care service plan shall not do either of the
- 10 following more than once each calendar year:
- 11 (1) Alter in any manner the rates that apply to individual plan
- 12 contracts.
- 13 (2) Alter in any manner any benefits included in individual plan
- 14 contracts.
- 15 (c) (1) If an enrollee changes geographic region or family
- 16 composition, the plan may alter the rates to reflect that change but

1 shall ensure that the change in the rates offered reflects only the
2 change in geographic region or family composition.

3 (2) If coinsurance obligations are based on a percentage of the
4 cost of services, nothing in this section shall prevent a change in
5 provider rates during the term of the contract even if that change
6 increases the charge for covered benefits to the enrollee.

7 (3) *If a brand name prescription drug becomes available as a*
8 *generic drug and if the prescriber does not specify use of the brand*
9 *name drug, the cost sharing for the enrollee shall be based on the*
10 *lower rate for the generic drug. Nothing in this paragraph shall*
11 *otherwise permit a plan to change the structure, tiers, or cost*
12 *sharing for generic and brand name drugs during the course of*
13 *the year.*

14 (d) *Upon issuance of a new individual plan contract consistent*
15 *with Section 1389.5, the provisions of this section shall apply to*
16 *that contract. In no instance shall a new individual plan contract*
17 *be issued more often than annually.*

18 ~~(d)~~

19 (e) This section shall not apply to health care service plan
20 contracts issued through a publicly funded state health care
21 coverage program, including, but not limited to, the Medi-Cal
22 program and the Healthy Families Program, or to Medicare
23 supplement contracts.

24 ~~(e)~~

25 (f) This section shall apply only to health care service plan
26 contracts issued, amended, or renewed on or after January 1, 2011.

27 SEC. 2. Section 10199.49 is added to the Insurance Code, to
28 read:

29 10199.49. (a) For purposes of this section, “rate” includes, but
30 is not limited to, premiums, copayments, coinsurance obligations,
31 deductibles, out-of-pocket costs, and any other charges for covered
32 benefits.

33 (b) Notwithstanding any other provision of law, except as
34 required by changes in state or federal law or as provided in
35 subdivision (c), a health insurer shall not do either of the following
36 more than once each calendar year:

37 (1) Alter in any manner the rates that apply to individual health
38 insurance policies.

39 (2) Alter in any manner any benefits included in individual
40 health insurance policies.

1 (c) (1) If an insured changes geographic region or family
2 composition, the health insurance policy may alter the rates to
3 reflect that change but shall ensure that the change in the rates
4 offered reflects only the change in geographic region or family
5 composition.

6 (2) If coinsurance obligations are based on a percentage of the
7 cost of services, nothing in this section shall prevent a change in
8 provider rates during the term of the policy even if that change
9 increases the charge for covered benefits to the insured.

10 (3) *If a brand name prescription drug becomes available as a*
11 *generic drug and if the prescriber does not specify use of the brand*
12 *name drug, the cost sharing for the insured shall be based on the*
13 *lower rate for the generic drug. Nothing in this paragraph shall*
14 *otherwise permit an insurer to change the structure, tiers, or cost*
15 *sharing for generic and brand name drugs during the course of*
16 *the year.*

17 (d) *Upon issuance of a new individual health benefit plan*
18 *consistent with Section 10119.1, the provisions of this section shall*
19 *apply to that plan. In no instance shall a new individual health*
20 *benefit plan be issued more often than annually.*

21 ~~(d)~~

22 (e) This section shall not apply to health insurance policies
23 issued through a publicly funded state health care coverage
24 program, including, but not limited to, the Medi-Cal program and
25 the Healthy Families Program, or to Medicare supplement policies.

26 ~~(e)~~

27 (f) This section shall apply only to health insurance policies *and*
28 *health benefit plans* issued, amended, or renewed on or after
29 January 1, 2011.

30 SEC. 3. No reimbursement is required by this act pursuant to
31 Section 6 of Article XIII B of the California Constitution because
32 the only costs that may be incurred by a local agency or school
33 district will be incurred because this act creates a new crime or
34 infraction, eliminates a crime or infraction, or changes the penalty
35 for a crime or infraction, within the meaning of Section 17556 of
36 the Government Code, or changes the definition of a crime within
37 the meaning of Section 6 of Article XIII B of the California
38 Constitution.

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